



February 27, 2009.

Ms. Barbara Miller,
Senior Policy Analyst,
Legislative Unit,
Manitoba Health and Healthy Living,
300 Carlton Street,
Winnipeg, MB R3B 3M9.

Dear Ms. Miller:

Re: Proposed Umbrella Health Legislation – The Regulated Health Professions Act

I write on behalf of the Opticians Association of Canada (OAC). The OAC is a national association representing the interest of Canadian Opticians. There are over 6,000 Opticians in Canada 265 of who reside in the province of Manitoba. We are pleased to have been able to participate as stakeholders in the consulting process regarding the proposed Regulated Health Professions Act (RHPA) and we herewith submit our comments on that document.

Summary

We appreciate the significant commitment that the Ministry has made to modernizing the regulation of health professions, including examination of notable policy principles and governance models used in existing regulated health professions legislation. The OAC has participated in consultations on health professions legislation in most provinces of Canada and in particular on those pieces that address umbrella legislation and the reserved activities concept. We believe in this document the Ministry has for the most part captured best practice for health care professionals as well as introducing welcome improvements.

The OAC supports a system that offers the public safe choices in health care services and health care professionals. One of the best tools in managing the ever-increasing burden of cost in our health care system is to maximize those choices through non-exclusive scopes of practice. This allows for educational growth and enhancement of skills in a profession thus better rationalizing existing human resources.

Another part of the toolbox is a carefully vetted list of activities that carry risk of harm. For the most part the OAC has limited comment about the list of reserved activities that has been compiled save for some confusion that we find in the definition section regarding the meaning of “contact lens”, “dispense”, “fit”, “verify” and “vision appliance”. We seek clarification of these terms since the current definitions do not seem to reflect our understanding of these terms.

Non-exclusivity in some sense represents a relaxing of regulation because it allows access to performance of reserved activities by individuals or groups of individuals who can demonstrate safe practice. But in fact the public is best served by creating a somewhat more complex but universal structure for the health professions within which practice can take place. Inherent in such a system is the necessity for transparency of process and ease of access to recourse. Finding the right balance is critical. Too much structure is costly and makes the system sluggish. Too little structure reduces accountability. We do not take issue with most of the governance model in this document.

The OAC is pleased that the government has addressed the matter of business arrangements and removing barriers to interdisciplinary practice. However we seek clarification in the section on Health Professions Corporations since it seems to enforce an existing anti-competitive position of some professions that prevents freedom of association.

Equally as important to safe choices is public familiarity with and access to regulatory schemes that are designed to protect their best interests. Creating a unified structure that embraces all health professions however layered that structure may be, is one step in that direction. Mandating public outreach and transparency by regulatory bodies goes further to creating a communication link between the regulatory bodies and the public they serve.

Part 2/Reserved Acts/Interpretation

3. Definitions

We are disappointed that the government has not taken the opportunity in this document to deal with the issue of the sale of plano-powered contact lenses (commonly referred to as cosmetic contact lenses) by unregulated persons. If a vision appliance is defined as being offered for a vision condition, tattoo parlours, flea markets, dollar stores and other unorthodox sellers will be able to (and have in the past) provide these lenses at some considerable health risk to consumers. We urge you to consider including cosmetic contact lenses in your definition of a contact lens. Legislation in the U.S. recognizes the potential danger to vision health of the unregulated sale of this product.¹

¹ [Bill S.172](#)

Reference is made to the perils of sale of cosmetic contact lenses by unqualified providers in an article that appeared in the 2003 Journal of the Contact Lens Association of Ophthalmologists, Inc. The article, Ocular Complications Associated with the Use of Cosmetic Contact Lenses from Unlicensed Vendors² provides case studies to support the position of the authors that,

“American young people remain at risk as a major target of the unauthorized sale of decorative contact lenses. Fashion-conscious teenagers are interested in colored contact lenses to change or enhance their eye color as demonstrated by models, movie stars, and music video entertainers. With a proper fit and appropriate instruction and follow-up by an eye care professional, the risks of decorative cosmetic contact lenses can be minimized, and lenses can be worn safely.”

The definitions of ‘contact lens’ and ‘vision appliance’ do not capture cosmetic contact lenses and therefore do not reflect the potential threat to vision represented by random provision of the product.

Contact Lens & Vision Appliance – Taken together these definitions seem to leave gaps in understanding. The text supporting the definition of a contact lens is not really a definition. It is merely a statement of inclusion. A contact lens is certainly a lens or mold but what separates it from any other lens is that it is designed to sit on the surface of the cornea. The OAC believes the definition should read, ‘A contact lens is a lens or mold designed to sit on the surface of the cornea.’

‘Contact lens’ also appears within the definition of a ‘vision appliance’. We suggest the best definition of ‘vision appliance’ would be:

“...an appliance or device that is designed or offered for a vision condition including corrective eyeglasses and contact lenses that are made or provided for use by a named individual, a contact lens that is designed for cosmetic purposes and a low vision aid, but does not include complete ready-to-wear corrective eyeglasses that are not made for use by a named individual.”

Orthokeratology and Corneal Refractive Therapy - The definition of a contact lens specifies orthokeratology or corneal refractive therapy. We do not believe that either of these terms needs to be included in the definition of a contact lens since both are merely applications of specific designs of contact lenses and are captured by a proper definition of a contact lens as we have recommended. If a person is qualified to fit contact lenses under regulation then he/she is qualified to fit any type of contact lens. The fitting protocol might be different than for an average lens but any time there is are new protocols related to emerging technology contact lens fitters must learn them. It is no different than when a manufacturer develops a new design of contact lens bifocals. A new product emerges or a new design of an old product and contact lens fitters must learn to use it appropriately.

² *Eye & Contact Lens* 29(4): 196–200, 2003

Corneal refractive therapy and orthokeratology are both terms to describe the reshaping of the cornea through non-surgical means in order to improve vision. Corneal Refractive Therapy or CRT is also used to describe a fitting protocol developed by Paragon Vision Sciences using a patented lens design. We are curious to know what distinction the government has placed on the two terms. As previously indicated we believe that it is not necessary to list these two contact lens applications but if specificity is required we recommend that only 'orthokeratology' is listed.

Verify – The OAC believes that verification of a vision appliance should be subjective. At some point in the dispensing continuum a verification of the appliance to the original authorization as well as to the intended wearer should take place. An objective verification serves only to validate the translation of the numbers that may be on the authorization into a vision appliance that meets the minimum standard set by the regulatory body. It does not validate the appropriateness of the vision appliance for the intended wearer. Under the current definition of 'verify' it is conceivable that the regulated individual might never see the intended wearer but merely sit in a back room comparing authorization to order to completed appliance.

Dispense and Fit – The definition of 'fit' is limited to a contact lens whereas the actions described in the definition also apply to eyeglasses. However eyeglasses appear only in the definition of 'dispense' under the general category of vision appliance; "...to design, supply, prepare, adjust or verify..." The OAC believes that "dispense" (c) and "fit" (a) (i) and (ii) should be incorporated together under a definition of 'dispense'.

What is a Reserved Act?

In British Columbia, Alberta and Ontario – the only three provinces that have enacted umbrella Health Professions Legislation - there have been three terms used for the list of activities that are considered to have a risk of harm to the public - reserved, restricted and controlled. The OAC notes that there is a trend in Canada toward harmonization of legislation and regulation in the professions and that recently in the course of negotiating the TILMA agreement British Columbia and Alberta settled on the term 'restricted'. The OAC believes it would be useful if that term were used in the Manitoba legislation as well.

List of Reserved Acts

17 & 18 – We make the same comment regarding "Prescribing, dispensing or verifying a vision appliance" and "Fitting a contact lens" as made previously in our comments on the Definitions section of this document.

Reserved Acts Restricted

The OAC believes strongly in the flexibility provided by legislation and/or regulations that are based on the restricted/reserved/controlled act system. The OAC also believes that delegation of these acts is appropriate under conditions as set out in profession-

specific regulation. However we are concerned about the meaning of the exemption clauses in this section of the document.

5(2) & 5(3) - There appear to be four categories of exemption. A person may be exempted, a class of persons may be exempted, an activity may be exempted and a class of activities may be exempted. The OAC understands that where overlapping scopes of practice exist there must be provision for exemption. This applies, for example to Opticians and Optometrists who share specific restricted activities. We also understand the exemptions detailed in 5(3)(b through g). However we ask for clarification on how 5(2)(a) relates to 5(2)(b) and how 5(3)(a) relates to 5(2). How may a person be exempted by regulation unless he/she is a member of a class of persons exempted by regulation? Why are there two separate sub-clauses describing persons or class of persons whereas activity or class of activities is combined into a single sub-clause?

Governance

College – The introduction to this document indicates that the governance model being proposed will require regulatory bodies to separate professional advocacy from regulatory activities. This is reinforced in section 10(3), which prohibits regulatory bodies from setting or negotiating fee schedules.

The OAC would like to observe that advocacy goes far beyond setting fees. The primary focus for a regulatory body is that of public interest. Although the underpinning of any health profession is to provide goods and services that will support better and safer health options for people, it's overarching goal is to advocate for the profession. In some cases this means that an association is at odds with the regulatory body. An example of this would be in the case of a disciplinary matter whereby the regulatory body could not provide advice and counsel for the member due to a conflict of interest. There are many other examples in which it would be difficult for the regulatory body to uphold its mandate and at the same time advocate for the member absent conflict of interest.

It is important for any health profession to be able to provide appropriate regulation of the profession but equally important to be able to sustain strong advocacy for the health professionals. This aspect of the proposed governance model parallels the approach taken in Alberta and in this case the result is Alberta Opticians do not have a provincial association and the regulatory body for Opticians does not believe there needs to be an advocacy group. They believe the only advocacy function they need to separate is that of negotiating fee schedules. The Alberta regulatory body has designated someone on their Council to negotiate fee schedules such as fitting fees for third party payment programs. They do, however provide liability insurance, group health insurance, continuing education opportunities and all other benefits that would normally attract membership to an association. These activities claimed by the Alberta regulatory body thus prevent, albeit unintentionally, the formation of an active association since no association would want to be in competition for member benefits with its regulatory body.

We believe this sets a bad precedent as it invites protectionism of the profession by the regulatory body to the detriment of its public interest mandate. The opposite could also occur whereby the regulatory body is unable to provide advocacy for opticians. We recommend that the governance conditions should specify that the profession must be able to sustain both an association and a regulatory body.

Part 5 Business Arrangements

The OAC congratulates the government on recognizing the importance of inter-disciplinary practice and on their efforts through this draft document to enable this practice model. The OAC also agrees with the requirement set out in this draft that health professions corporations should have to register with the profession's regulatory body. This ensures that the regulatory body will be aware of all locations in which a health profession corporation is practicing therefore enabling the regulatory body to ensure that reserved activities are being performed by the appropriate individuals.

Part 5 is quite properly places the onus of responsibility when a regulated health professional works for a corporation going so far in clause 54 to articulate duty where a conflict of interest exists. This is excellent. However clause 51(2) mandates that only persons who are in the same regulated health profession may form a health profession corporation. We believe this not only restricts freedom of association between allied health professionals but also legitimizes the entrenched position of those professions that heretofore have taken an elitist approach to cross-professional collaboration. We note section 65(2) that contemplates 'practice in association' and collaboration on shared practice services but we are unclear on how this would in reality differ from a working with a Health Professions Corporation.

We are also concerned that 51(3) restricts any corporation other than a health profession corporation from carrying on the practice of a health profession. Often Opticians work in a retail environment and many are employees of retail chains stores in the same way that pharmacists work in retail pharmacies. The chain stores are corporations. Their owners are not regulated health professionals.

Title Restriction and Other Prohibitions

The question posed under this section speaks to the matter of whether title protection should appear in umbrella legislation or in regulation. The OAC believes that the legislation should enable title protection.

Part 10 Health Professions Advisory Council

The OAC recognizes the amount of work involved in developing, consulting on, vetting and implementing regulation and/or changes to regulation. The creation of a Health

Professions Advisory Council (HPAC) follows the model used in B.C., Alberta and Ontario. The Ontario Regulated Health Professions Act is the longest standing of these and their Health Professions Regulatory Advisory Council the advisory body with the most experience. Yet in its 2006 report to the Ontario Minister of Health New Directions³ described consultation with the regulatory bodies on the matter of the approval process for regulations.

HPRAC found that according to the regulatory bodies response from the Ministry to requests from the professions for approval of regulation were sluggish at best and in some cases taking as long as six years. The apparent blockage was not at the level of HPRAC but within the ministry itself partially due to either lack of transparency or lack of significant broadcast of the protocols involved.

With that said, we still acknowledge the potential value of an advisory board but note that it is important to avoid politicizing the health care system. It is unfortunate that historical paradigms for health care professionals and exclusive scopes of practice has evolved into a turf protecting system that the Manitoba Law Reform Commission report Regulating Professions and Occupations described as follows:

“...Powerful and well-connected groups of practitioners are more likely to succeed in their objectives by lobbying than less influential groups. This raises the prospect that some practitioner groups will be treated unfairly but, more importantly, it suggests that occupational regulation may be employed to protect and enhance the interests of certain groups of practitioners rather than the interests of the public as a whole.”

Many proposals for change in regulation or scope of practice involve opposition from competing stakeholders that amounts to turf protection. The OAC realizes that it is impossible to construct membership on an advisory board where conflict of interest will never arise. However we recommend that there should be a clause in this section that makes it a requirement that the panel members recuse him or herself in a situation where a member may have a real or perceived conflict.

Part 14 Regulations and By-laws

Council Regulations

Pending clarification of the relationship between the Health Professions Corporation and ‘practicing in association’, we believe that 162 (1)(p) serves to reinforce the current anti-competitive nature of optometric regulation and by-laws regarding conflict of interest by restricting the persons or class of persons with whom members may practice in association. Optometrists have held that if optometrists were to work with opticians on an equal footing the ethics of the optometrist would be seen to be compromised and they have used their authority to impose restrictions such as those set out in the above-quoted clause to justify this position. The case has frequently been made and even validated in

³ Regulation of Health Professions in Ontario: New Directions April 2006

the court system⁴ that an optometrist working for an individual other than an optometrist would be no more ethically compromised than he/she is under their current business model whereby an optometrist may diagnose, prescribe and sell product.

162(1)(q) allows council to restrict the persons or class of persons to whom and from whom members may refer. This authority has been used in the past as leverage in conflicts between professional groups.

This document has been very clear in stating the onus of ethical responsibility, which rests with the health care professional. This should be sufficient to guide the individual in whichever practice model he/she chooses including practicing in association and referral situations. We believe this authority to proscribe the working relationships of health care professionals should be removed.

Conclusion

The OAC respectfully submits these comments and looks forward, along with our members in Manitoba to future opportunities to have input as the process of further development and implementation of this document proceeds.

Yours truly,



Mary Field,
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OAC National Affairs

⁴ IN THE MATTER OF THE JUDICIAL REVIEW PROCEDURE ACT, R.S.B.C. 1979, c.2090
CostcoWholesale et al v. Board of Examiners of Optometry